Learning Journey

GRET

Health Insurance Project (HIP) for the garment sector in Cambodia –
To refine the piloted health insurance programme in preparation for transfer to
the National Social Security Fund (NSSF)

This Learning Journey was created with contributions from:
Pascale Le Roy (GRET), and Caroline Phily and Alice Merry (the Facility)

Contents

Project Basics ........................................................................................................................................ 2
About the project .................................................................................................................................. 2

Project Updates .................................................................................................................................... 3
KPIs ......................................................................................................................................................... 3
What has happened? ............................................................................................................................... 4

Lessons .................................................................................................................................................. 8
On transferring knowledge from a pilot to a national scheme .............................................................. 8
On technology ....................................................................................................................................... 8
On distribution ....................................................................................................................................... 9
On client value ..................................................................................................................................... 10
On promotion ......................................................................................................................................... 11

Next Steps ........................................................................................................................................... Error! Bookmark not defined.
Project Basics

About the project

GRET is a French NGO which has been active in Cambodia since the late 1980s. It has been working on health microinsurance in the country for over ten years, as it believes that health microinsurance is an appropriate means of protection for the poor households it targets: several studies have confirmed that health risks are a leading predictor of poverty for rural households in Cambodia, a country where health conditions are among the worst and families have to spend the most on care.

In the past there has been no social security at all in Cambodia, even for formal workers. However, in the last few years there have been some moves towards covering formal workers. Currently there is a national social security fund (NSSF), which offers coverage for accident risks, and plans to cover health.

Since 2009, GRET has been piloting its Health Insurance Project (HIP) with funding from l’Agence Française de Développement, and in partnership with the Garment Manufacturers’ Association of Cambodia (a union for employers in the garment sector). This project is developing health insurance services for workers in the garment sector in Cambodia. The aim was to pilot a scheme which could be transferred to a national scheme in the near future, as agreed with the National Social Security Fund (NSSF).

This project serves workers from the garment industry of Cambodia. Garment workers are mainly young, single and rural migrant women. Their average monthly salary is around US$ 79. They use as little of their salary as possible to support themselves so as to remit as much as possible to their home villages. As young workers lacking experience and social support, they are vulnerable to accidents and illness.

For a premium of US$ 1.60 per worker per month (50 per cent co-funded by those) HIP provides comprehensive coverage of medical services from basic primary health care to complicated surgery in contracted public health facilities in and around Phnom Penh. As of mid-2012, HIP covered more than 6,000 workers.

GRET planned to finalize its operations and upgrade its information systems, ready to transfer the programme to NSSF. The grant from the Microinsurance Innovation Facility was made to support GRET to make these preparations. This transfer would also involve support in the form of staff training, and adapting processes and procedures, backed up by a robust information system, and sharing of lessons learned on technical issues such as monitoring, premium setting, enrollment and payment mechanisms, and authentication procedures.

You can see more about GRET’s work in its video: 10 years of social health protection in Cambodia.

Project Summary

<table>
<thead>
<tr>
<th>Project name:</th>
<th>Health Insurance Project for the garment sector in Cambodia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project start date:</td>
<td>July 2011</td>
</tr>
<tr>
<td>Duration:</td>
<td>1 year</td>
</tr>
<tr>
<td>Country:</td>
<td>Cambodia</td>
</tr>
<tr>
<td>Product:</td>
<td>Health</td>
</tr>
</tbody>
</table>
The HIP claim ratio is satisfactory in terms of value for clients since 75 per cent of the premium collected has been returned in claims at the end of 2010 and 79 per cent in 2011. Despite a comprehensive benefit package that includes primary health care, the risk of over consumption is well under control, since HIP health care provider payment is mainly based on lump sum payments per IP (in-patient) or OP (out-patient) case. With tighter control on drugs reimbursement (with a list of covered drugs) and the majority of HIP members being automatic members, the claims ratio has been decreasing since 2012 to reach an average of 50% as of September 2013.

The HIP health insurance pilot scheme’s net income ratio is currently negative with a value of -75 per cent at the end of July 2012. However the trend is positive as HIP gross income (earned premium – incurred claims) is increasing faster than HIP operating expenses that remained at a rather stable level. Overall, the HIP scheme currently fully covers the claims of insured workers but not all the operating expenses given its limited membership. The gap was subsidized by donors until the end of September 2013 and after that directly financed by NSSF.
What has happened?

Inception of the project

In 2007, GRET conducted a feasibility study to develop a health microinsurance product targeting the garment workers of Cambodia, who represent the major part of Cambodia’s formal employees. Garment workers are to be covered in the future by the NSSF health coverage, but as coverage was not expected to roll out for a few years, the Garment Manufacturers Association in Cambodia (GMAC), an employers’ union, asked GRET to use the intervening time to test the possible design of the NSSF scheme. GRET therefore launched the Health Insurance Project (HIP), financed by the French Government, in 2009. Its objectives were to:

- Develop the health insurance benefit package
- Define the main business processes
- Design and develop tools (information and management system, marketing and client service) and methodologies (monitoring of the relationship with factories, contracting and monitoring of health-care delivery, risk management), and transfer them to NSSF
- Stabilize the statistical and financial data necessary for the definition of the contribution
- Pave the way for the industry stakeholders (employers, unions, and government) to understand the challenges related to the management of the scheme and to measure the importance of investing in health

The governance of the project is undertaken by a board of administration, composed of GMAC and GRET. A steering committee involving representatives of employers, labour unions and employees, as well as representatives of the ministries concerned (labour, health, and finance) and the NSSF was created in 2009.

The context of the project

The project has struggled with the economic crisis in the garment sector, which has made factory managers reluctant to invest in the scheme. There has been increasing tension between factory workers and employees. International competition puts constant pressure on wages. At the same time, employees strike for better wages and working conditions, and an increase in the occurrence of mass fainting in garment factories has put pressure on the issue of working conditions in the sector.

The minimum wage in factories increased in January 2012, but strikes continued to increase regarding salaries and working conditions. The increased minimum wage for factory workers has not benefitted the project, since the employee’s share of the premium for HIP is seen by many factories as an additional burden on top of increased wages. However, HIP did benefit from a positive economic trend in the garment sector. HIP saw an increasing number of workers from the three factories that joined HIP with automatic membership for all workers.

Group versus voluntary coverage

HIP was originally planned as a group insurance product with automatic membership for all workers when a factory decides to join. However, given the crisis in the garment sector in 2009, HIP was forced to become a voluntary product in most cases. Once the factory management decides to adopt HIP, workers can chose whether they want to buy health insurance, and will have to pay 50 per cent of the
premium. Only three factories out of 11 chose to implement automatic membership with employers paying 100% of the premium.

**Promotion**

Routine sales are carried out by three people visiting factories and recruiting workers. They are young urban employees with a baccalaureate or higher, and some marketing or sales experience. Their training is relatively ad hoc, and focuses on the needs of garment workers and their views on health insurance.

Factories are initially approached through the Garment Factory Association. The HIP team first speaks to the HR manager and then to the director of the factory (often based externally to Cambodia). If the team can win their support then it will seek authorization to approach workers directly.

Despite intensive promotion of HIP to more than 20 target factories with the support from GMAC, it has been very difficult to recruit new factories since 2011. Factory managers were often reluctant to join the project, arguing that they preferred to wait for the compulsory system to start.

**Technology**

A specialized management information system (MIS), enabling customized reports for factories, and a fingerprint recognition mechanism were developed. In addition, an SMS system was developed to identify clients in case this is not possible through the fingerprint recognition mechanism system because of no internet or electricity access or no hostess at a health care facility.

It has been important to make decisions on systems and technology with NSSF to make sure that they can be transferred; however in some cases this has delayed the process. Delays in decision-making on the part of NSSF slowed down the development of the HIP MIS version three, and of specific IS modules for factories and health facilities. This situation has in turn restricted the time dedicated to testing the new modules. However, MIS version three did go live in 2012, with specific access for factories and contracted health facilities.

GRET also chose the fingerprint system in dialogue with NSSF. The system was successfully deployed and integrated into the MIS. A manual was also created to guide use of the fingerprint recognition system. This manual has been passed on to NSSF.

The collection and monitoring of health data has been improved through direct data entry by the hostesses. This has allowed the production of standardized health consumption reports. This gives information about the consumption of health services at each health facility.

**Customer care**

To make sure that HIP members are well served, and to get regular feedback from them, HIP has developed a three pillar strategy:

1. Weekly presence at the factory
2. A 24/7 hotline and complaint system
3. Hostesses at health facilities to accompany insured members
The intention of the complaints system was for the factories to access it directly, so that they can track how well the programme is working for its employees. GRET evaluated its use in one factory, but in fact found that staff prefers to rely on the HIP team to give them feedback on workers’ complaints, than to look into the complaints system themselves. However, this system is likely to become more important with the compulsory national scheme, to monitor the scheme and ensure good value.

The most recurrent complaints were related to difficulties arising when members did not understand the coverage or the process to follow, or when clients did not feel that providers behaved well with them.

GRET trained NSSF on the complaints system in 2011, and NSSF is already planning to use the system for its work injury insurance scheme. This should provide useful preparation for using the system when it takes over the health scheme.

The introduction of hostesses has proved particularly successful in improving customer care. The hostess helps clients to feel comfortable at the health facilities and helps them in case of problems.

**Transfer to the national scheme**

NSSF initially announced (informally) that the social health insurance would become compulsory in 2011, and then changed the date to early 2012. In the end this date was again delayed until 2013. There is a great deal of uncertainty, with no clear road map for how the national scheme will proceed. Uncertainty regarding the official date for the launch of the national scheme has plagued the project. Factory managers usually prefer to wait for the launch instead of joining HIP, limiting HIP’s growth. The changes to the launch date have also put financial pressure on the project, as the donor funding was originally supposed to end in 2011.

Insights and project developments have continuously been shared with NSSF in order to facilitate the transfer of the pilot to the national scheme. GRET insisted on the involvement of NSSF from the beginning of the project, to make sure that the NSSF built a sense of ownership of the results. NSSF did show an interest in being involved in the project and a memorandum of understanding was signed between all partners, outlining the role of each party. Quarterly steering committees were also planned. In addition, GRET proposed that key counterparts from NSSF be work in collaboration with the HIP team on a regular basis. However, NSSF were not interested in this final proposal. Workshops to exchange lessons learn have been conducted during the first phase of the project. However transfer of HIP activities and processes to NSSF at the end of the project period did not take place, due to the confusion around how the national scheme will progress.

Eventually, with support from AFD (Agence Française de Développement), a next phase of the project was agreed up to the planned start of the national scheme in September 2013.

In October 2013, GRET transferred its 7,144 HIP clients to NSSF. NSSF also took on 17 key staff from the scheme, including eight hostesses located in contracted public health-care facilities. NSSF is therefore now managing the HIP scheme, which will become part of the compulsory national scheme (expected in July 2014 but not officially confirmed yet). NSSF is now upgrading the HIP MIS developed by GRET, so that the system will be ready to manage the national scheme in its first phase (midterm IT solution).
GRET will continue to offer technical assistance until July 2014 to help NSSF in managing HIP previous contracts while supporting NSSF on specific technical issues in preparation to the launch of the compulsory health insurance scheme.

**Experimenting with private providers**

Due to concerns about the absence of public facilities near factories, and upon request from factories, GRET decided to experiment with private health providers. At the moment, GRET is piloting contracting one private provider for OP care. It is important to note that GRET prefers to partner with public health providers in order to contain costs and to work within a regulated environment. However, GRET decided to test a partnership with a private provider since NSSF does plan to contract private providers for its coming national health insurance scheme.

The pilot was launched in January 2013 after being validated with NSSF and the Ministry of Health. In order to limit overconsumption, a co-payment has been enforced for use of this provider. Three months into the pilot it is already emerging that clients prefer to pay the transport costs to reach a public provider than to pay the co-payment at the private facility.
Lessons

On transferring knowledge from a pilot to a national scheme

It is possible to use the pilot scheme to influence the national scheme, and promote the interests of the beneficiaries. In its discussions with NSFF, the HIP team regularly insists on the importance of the satisfaction of insured members. This was not initially seen as a major priority for the NSSF team, but the continuous dialogue between the HIP and NSSF teams has allowed the HIP team to build awareness of the issue. This has resulted in NSSF requesting to use the HIP compliant system as a tool to monitor client satisfaction.

GRET has advocated for NSSF to continue to include its peer education, including education on family planning, as part of the national scheme. NSSF see the value in such preventative health schemes, but it is not yet clear if and how they will scale these initiatives up to cover the whole country.

Pilots need to be integrated as part of the national strategy, with clear objectives, methodology, and monitoring. Better transfer might have been achieved through ensuring a stronger buy-in from all stakeholders in the project, and by ensuring that the pilot was a fundamental part of the government national strategy. All stakeholders should jointly design the pilot’s objective, and agree on a strategy to ensure the pilot’s success and the transfer of key elements. The pilot end date needs to be clear and an exit strategy should be established (whether the pilot is successful or unsuccessful). When pilot phases are dependent on donor support, their duration is contingent on available funding, and it is important that this matches the role out date of the planned scheme.

The project has been impacted greatly by the absence of a clear roadmap and management capacities on the part of NSSF. This has created a great deal of uncertainty regarding the appropriate strategy for the HIP project. Furthermore, it has been difficult to convince factory managers to adopt HIP when there are constant delays to the compulsory health insurance. Given the uncertainty over the date of the launch of the national scheme, factory managers prefer to wait and see.

On reflection, the HIP team feels that the best scenario would have been if the NSSF directly initiated the pilot project. However, experiences of other projects in Cambodia show that projects initiated by other actors, such as NGOs, in dialogue with appropriate ministries can be successful in putting issues on the policy makers’ agenda, without waiting too long to address the needs of vulnerable populations.

Human resources, and the knowledge they hold, can be lost without a clear plan for transfer of the scheme and for those involved in it. The project faced the issue of the future of employees recruited and trained to manage the temporary health insurance project. This issue is particularly sensitive in settings without employment benefits, as staff will look for jobs before the end of the temporary project in order to avoid gap in employment. This situation complicates the management of the temporary project, since these employees are needed to maintain the health insurance contracts until the start of the compulsory health insurance. As in many other countries, people with the capacity to manage health insurance are still rare. Therefore uncertainty of the date of transfer to the national health insurance scheme may result in a loss of staff, which can in turn jeopardize the transfer process.

On technology

It has also been important to find ways to adapt the system to places where electricity is scarce. A system using SMS messaging has therefore been put in place to cater to these limitations. The offline
SMS system is particularly important for clients, as it ensures that the insured can be identified even at night, or in locations where the internet isn’t working. This in turn ensures that clients aren’t charged by hospitals who cannot confirm their identity.

**Fingerprint systems can reduce fraud but increases registration time.** While the fingerprint system has improved fraud control, it has proved time consuming for the registration process. The new registration process takes three minutes per client, whereas the paper process took only one minute. This is particularly sensitive for factory workers, who do not have a lot of time to register during their lunch or other breaks.

**The HIP teams have found that several technology considerations are particularly relevant given the plans to transfer to a national scheme:**

- Open source solutions offer more flexibility for transfer of the MIS to the national scheme
- The pace of the project will frequently be affected by the political agenda of the public institution
- Identification system needs careful consideration as portability must be anticipated when designing a national scheme and its future links with pension schemes, for example.

**Providing detailed consumption report to factories empowers them to push for better value.** Factory managers are demanding in terms of data, so that they can assess the value of the product and decide whether it makes sense for them to continue their membership of HIP. They look at the claim ratio and the total costs avoided compared to the premium they have paid. Based on this kind of report and analysis, one factory (CTW) asked HIP to contract a private provider near by the factory to make sure that the workers insured have a suitable access to health care in the absence of a public health care facility nearby.

**On distribution**

**It is important to work with both employers’ and workers’ unions to create a more conducive environment for distribution.** This has been difficult, given escalating tension between the groups and increased strikes, but, where possible, helps reduce the antagonism that usually arises between workers and managers around health insurance services. When workers’ unions and employers’ unions speak with one voice (although often for different reasons) about the benefits HIP can bring to workers, it is much easier for the HIP team to gain the confidence of the workers and achieve a satisfactory membership rate.

**Workers’ unions may not be highly supportive of attempts to distribute the product.** Workers’ unions have their own agenda, and do not tend to prioritize health insurance, since wages are their immediate priority. Even where they are supportive of health insurance, unions often disagree with elements of the scheme, particularly how it should be funded. In meetings with the HIP team, federations of unions showed a strong interest in health insurance for workers. However, they believed that employers should pay 70 per cent of the premium, rather than 50 per cent as proposed for the national scheme. Such disagreements may dissuade unions from supporting the HIP project.

Furthermore, employers’ unions cannot always convince the workers’ representatives. Their power is quite limited since they do not want to put pressure on the workers and risk a strike if they are not satisfied with the product.
On client value

When designing the benefit package, it has been important to use a social protection approach from the beginning. GRET therefore believes that it is important to provide a comprehensive package that provides both primary and hospital care, and to do so on a cashless basis. It has also given specific attention to reproductive health, since most of its insured members are young women. At the same time, it has been important to find a balance between the value of the product and its affordability. HIP has therefore contracted primarily public health providers, which have lower fees.

Public health facilities may not provide sufficient value to clients, due to their distance from some factories and poor quality in some cases. Workers often have high transport costs to reach public facilities. In addition, public facilities have a particularly low reputation for primary care, and this causes dissatisfaction for insured workers. The HIP project found that, particularly in urban settings, workers strongly prefer private providers. Factory managers who dismissed the HIP offer stressed the need for a greater number of partner health providers for primary care.

GRET is therefore testing the feasibility of also contracting private health providers and the potential impact of doing so on premiums. It is currently testing a partnership with one private health provider for OP care only. The pilot is being conducted in dialogue with the NSSF and ministry of health. In order to limit overconsumption, a co-payment has been enforced for use of this provider. Three months into the pilot it is already emerging that clients prefer to pay the transport costs to reach a public provider than to pay the co-payment at the private facility.

Private providers may also be unsatisfactory, since the ministry of health does not fully regulate private providers and there is no accreditation system yet. As a result, it is difficult and time consuming to check the quality of private providers before contracting them. For the pilot, this quality checking will be carried out in dialogue with NSSF and field partners, including the ministry of health, and other United Nations and aid organizations.

The proximity of healthcare facilities is one important factor in determining how often they are used. It was expected that factories with automatic membership would have fewer visits per member. Fewer visits were recorded for two of the factories with automatic membership, as expected, but not for one, which is closer to health facilities and shows a high frequency of visits for both IP and OP care. Proximity to health facilities does play an important role in easing access to health care for clients.

Dropout rates are low. The percentage of clients renewing their policies is high, ranging from 68 per cent to 97 per cent in different factories. Clients seem to be lost more often because they stop working at the factories rather than because they are not satisfied with the product. However, in order to decrease dropouts, two main measures were implemented: peer educators were selected from among the workers at each factory to encourage membership on an ongoing basis in voluntary factories; and automatic renewal of contracts was introduced, provided the worker does not indicate a desire to leave the scheme.

The complaints system has enabled better tracking of client value. For the year 2012, 25 cases of major complaints were recorded and addressed. The most recurrent complaints were related to difficulties arising when members did not understand the coverage or the process to follow, or when clients did not feel that providers behaved well with them. Systematic follow up of the complaints has allowed improvements HIP services, particularly clarification of the benefit package.
Access to a complaints system and face-to-face feedback has proved a powerful combination. The complaint system is used to record all complaints that are collected by the hostesses, officers at the health facilities, the HIP communication team, medical advisors and claim officers. In fact, HIP workers within the factories have not tended to call the complaints hotline directly to report complaints. Rather they tend to inform their HR manager, who calls the HIP communication team through the hotline.

Frequent contact with factories’ HR departments allows the HIP team to update the list of members and receive regular feedback directly from HR managers, in addition to the hotline. Being present at the factories every one or two weeks ensures a smooth relationship with HR departments in factories, as well as an opportunity to provide regular information to workers.

The hostess system has proved a particularly effective tool to help clients clarify processes for them, thus reducing complaints. They are also able to collect feedback and observe problems.

The three channels are therefore complementary, and the combination has proved worthwhile.

Flat rate lump sum payments to providers may make provision of OP care more feasible. The HIP project adopted a very simplified method of payment for IP and OP care, paying a single flat rate lump sum for IP and a single flat rate for OP to providers. This has allowed it to offer OP care without creating too great an additional administrative burden or cost.

On promotion

It is particularly challenging to find the time and spaces to communicate and promote the product with factory workers. Workers’ representatives have been very important to help the HIP team find ways to promote the product, and to facilitate discussions with workers. It is difficult to capture workers’ attention, but where the factory has a canteen, the HIP team has found opportunities to approach workers during lunch breaks. The factory sound systems can also be used to communicate key messages to workers. Songs, leaflets, posters, and an interactive game are also used to explain the product and convince workers of its benefits.

Where cover is automatic promotion and communication efforts can be adapted according to claims levels. In factories with automatic membership, HIP pays a lot of attention to making sure that the members have the correct information on their cover and make the best use of it. When the claim ratio for a factory becomes too low, the HIP team adjusts its strategy to spend more time in that factory to better inform members (especially newly recruited workers) and collect feedback to check for dissatisfaction with the service.